Complete Summary

GUIDELINE TITLE

Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder.

BIBLIOGRAPHIC SOURCE(S)

American Psychiatric Association. Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Arlington (VA): American Psychiatric Association; 2004 Nov. 57 p. [463 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- On May 12, 2006, GlaxoSmithKline (GSK) and the U.S. Food and Drug Administration (FDA) notified healthcare professionals of changes to the Clinical Worsening and Suicide Risk subsection of the WARNINGS section in the prescribing Information for Paxil and Paxil CR. These labeling changes relate to adult patients, particularly those who are younger adults.

  A recent meta-analysis conducted of suicidal behavior and ideation in placebo-controlled clinical trials of paroxetine in adult patients with psychiatric disorders including Major Depressive Disorder (MDD), other depression and non-depression disorders. Results of this analysis showed a higher frequency of suicidal behavior in young adults treated with paroxetine compared with placebo. Further, in the analysis of adults with MDD (all ages), the frequency of suicidal behavior was higher in patients treated with paroxetine compared with placebo. This difference was statistically significant; however, as the absolute number and incidence of events are small, these data should be interpreted with caution. All of the reported events of suicidal behavior in the adult patients with MDD were non-fatal suicide attempts, and the majority of these attempts (8 of 11) were in younger adults aged 18-30. These MDD data suggest that the higher frequency observed in the younger adult population across psychiatric disorders may extend beyond the age of 24.

It is important that all patients, especially young adults and those who are improving, receive careful monitoring during paroxetine therapy regardless of the condition being treated. See the FDA Web site for more information.

- On December 8, 2005, the U.S. Food and Drug Administration (FDA) has determined that exposure to paroxetine in the first trimester of pregnancy may increase the risk for congenital malformations, particularly cardiac malformations. At the FDA's request, the manufacturer has changed paroxetine's pregnancy category from C to D and added new data and recommendations to the WARNINGS section of paroxetine's prescribing information. FDA is awaiting the final results of the recent studies and accruing additional data related to the use of paroxetine in pregnancy in order to better characterize the risk for congenital malformations associated with paroxetine.

  Physicians who are caring for women receiving paroxetine should alert them to the potential risk to the fetus if they plan to become pregnant or are currently in their first trimester of pregnancy. Discontinuing paroxetine therapy should be considered for these patients. Women who are pregnant, or planning a pregnancy, and currently taking paroxetine should consult with their physician about whether to continue taking it. Women should not stop the drug without discussing the best way to do that with their physician. See the FDA Web site for more information.

- On September 27, 2005, GlaxoSmithKline (GSK) and the U.S. Food and Drug Administration (FDA) notified healthcare professionals of changes to the Pregnancy/PRECAUTIONS section of the Prescribing Information for Paxil and Paxil CR Controlled-Release Tablets to describe the results of a GSK retrospective epidemiologic study of major congenital malformations in infants born to women taking antidepressants during the first trimester of pregnancy. This study suggested an increase in the risk of overall major congenital malformations for paroxetine as compared to other antidepressants [OR 2.2; 95% confidence interval, 1.34-3.63]. Healthcare professionals are advised to carefully weigh the potential risks and benefits of using paroxetine therapy in women during pregnancy and to discuss these findings as well as treatment alternatives with their patients. See the FDA Web site for more information.
- On July 1, 2005, in response to recent scientific publications that report the possibility of increased risk of suicidal behavior in adults treated with antidepressants, the U.S. Food and Drug Administration (FDA) issued a Public Health Advisory to update patients and healthcare providers with the latest information on this subject. Even before the publication of these recent reports, FDA had already begun the process of reviewing available data to determine whether there is an increased risk of suicidal behavior in adults taking antidepressants. The Agency has asked manufacturers to provide information from their trials using an approach similar to that used in the evaluation of the risk of suicidal behavior in the pediatric population taking antidepressants. This effort will involve hundreds of clinical trials and may take more than a year to complete. See the FDA Web site for more information.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Acute stress disorder and posttraumatic stress disorder

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Psychiatry

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To assist psychiatrists in the assessment and care of adult patients with acute stress disorder (ASD) and posttraumatic stress disorder (PTSD)

TARGET POPULATION

Adults (18 years of age and older) with suspected acute stress disorder or posttraumatic stress disorder, according to the criteria defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)

INTERVENTIONS AND PRACTICES CONSIDERED

Assessment/Diagnosis

1. Differential diagnosis of acute stress disorder (ASD) and posttraumatic stress disorder (PTSD) according to Diagnostic and Statistical Manual of Depression, 4th Edition (DSM-IV) criteria
2. History of traumatic experience
3. Complete psychiatric evaluation
4. Functional assessment
5. Determination of and treatment of comorbid physical or psychiatric disorders (including major depressive disorders, anxiety disorders, and substance use disorders)
6. Determination of comorbid somatization disorder or other somatoform disorders
7. Assessment of patients risk for suicide
8. Assessment of patients potential to harm others

Psychiatric Management

1. Establishment of a therapeutic alliance with the patient
2. Patient education regarding acute stress disorder (and posttraumatic stress disorder)
3. Enhancement of treatment adherence
4. Coordination of care by collaborating with other clinicians
5. Psychotherapeutic and psychoeducational interventions
6. Monitoring of patient's treatment response
7. Monitoring for comorbid medical conditions or substance abuse disorders
8. Clinical assistance for family members who may require intervention
9. Assistance with life issues (e.g., family and social relationships, living conditions, vocational issues, and financial support)

Pharmacotherapy

1. Selective serotonin reuptake inhibitors (SSRIs)
    - Fluoxetine
    - Sertraline
    - Paroxetine
    - Fluvoxamine
    - Citalopram
2. Tricyclic antidepressants
    - Amitriptyline
    - Imipramine
    - Desipramine
    - Phenelzine
3. Monoamine oxidase inhibitors (MAOIs)
    - Phenelzine
    - Brofaromine
    - Moclobemide
4. Other antidepressants
    - Nefazodone
    - Trazodone
    - Bupropion
    - Venlafaxine
    - Mirtazapine
5. Second-generation antipsychotic medications

- Olanzapine
- Quetiapine
- Risperidone

6. Anticonvulsants
    - Divalproex
    - Carbamazepine
    - Topiramate
    - Lamotrigine
    - Tiagabine*

      *Note from the National Guideline Clearinghouse: On February 18, 2005, the U.S. Food and Drug Administration (FDA) announced that a bolded Warning will be added to the labeling for Gabitril (tiagabine) to warn prescribers of the risk of seizures in patients without epilepsy being treated with this drug. Although Gabitril has been shown to reduce the frequency of seizures in patients with epilepsy, paradoxically, Gabitril´s use has been associated with the occurrence of seizures in patients without epilepsy. Gabitril is approved for use only as adjunctive therapy in adults and children 12 years and older in the treatment of partial seizures. Because Gabitril has not been systematically evaluated in adequate and well-controlled trials for any other indication, its safety and effectiveness have not been established for any other use. Cephalon will undertake an educational campaign to discourage off-label use of Gabitril. See the FDA Web site for more information.

7. Other therapeutic agents
    - Benzodiazepines, including alprazolam
    - Valproic acid
    - Cyproheptadine
    - Inositol
    - Alpha-adrenergic blockers, including prazosin and clonidine
    - Beta-adrenergic blockers, including propranolol
    - Chloral hydrate
    - Lithium carbonate

Psychotherapeutic Interventions

1. Cognitive behavior therapy
2. Patient utilization of existing support network
3. Psychological debriefing
4. Single-session therapy
5. Eye movement desensitization and reprocessing (EMDR)
6. Reactive eye dilation desensitization and reprocessing (REDDR)
7. Hypnotherapy
8. Desensitization
9. Stress inoculation
10. Imagery rehearsal
11. Prolonged exposure techniques
12. Case management
13. Group therapies including present-centered and trauma-focused group therapies

14. Optimism training
15. Goal setting and achievement
16. Biofeedback
17. Multiple channel exposure therapy
18. Assertiveness training
19. Relaxation exercises
20. Internet based therapies
21. Outward Bound group recreational therapies

MAJOR OUTCOMES CONSIDERED

- Reduction in severity of acute stress disorder (ASD) and posttraumatic stress disorder (PTSD) symptoms
- Prevention/reduction of trauma-related comorbid conditions
- Patient adherence to treatment plan
- Response to treatment
- Speed of recovery
- Social, occupational, adaptive, and interpersonal functioning
- Length of hospitalization
- Quality of life
- Rate of relapse

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Relevant literature was identified through a computerized search of MEDLINE and the Published International Literature on Traumatic Stress (PILOTS) database, produced by the National Center for Post-Traumatic Stress Disorder and available online (http://www.ncptsd.org//publications/pilots/index.html). An initial search of PubMed was conducted for the period from 1966 to 2002. Key words used were posttraumatic stress, stress disorder, acute stress disorder, posttraumatic stress disorder, and PTSD. Additional citations were identified by using key words emotional trauma, psychic trauma, posttraumatic, disaster, terrorism, rape, assault, physical abuse, sexual abuse, childhood abuse, combat, traumatic event, and traumatic incident and then limited to citations that included the key words stress, psychological sequelae, anxiety, and dissociation. In determining which of the identified citations related to treatment, key words used were treatment, management, therapy, psychotherapy, antidepressive agents, tranquilizing agents, anticonvulsants, debriefing, critical incident, eye movement desensitization, and EMDR. Citations were further limited to clinical trials or meta-analyses published in the English language and accompanied by abstracts. A total of 316 citations were found. When applied to the PILOTS database, this search strategy yielded a total of 587 citations, many of which were duplicates of those obtained in the PubMed search. Additional, less formal literature searches were

conducted by American Psychiatric Association (APA) staff and individual work group members. Other published guidelines for the treatment of ASD and PTSD were also reviewed.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Articles identified in the initial literature search were prioritized for review according to methodological strength. Highest priority was given to randomized, placebo-controlled trials of psychotherapeutic and psychopharmacological interventions for individuals with a diagnosis of acute stress disorder (ASD) or posttraumatic stress disorder (PTSD). The work group review process identified further citations that included randomized and open trials, literature reviews, meta-analyses, and other studies that were incorporated into evidence tables in an iterative manner. In interpreting the conclusions of these studies, consideration was given to factors that could limit the generalizability of the findings, including differences between individuals enrolled in well-controlled efficacy trials and individuals seen in clinical practice. Consequently, the recommendations for any particular clinical decision are based on the best available data and clinical consensus. The summary of treatment recommendations is keyed according to the level of confidence with which each recommendation is made. In addition, each reference is followed by a letter code in brackets that indicates the nature of the supporting evidence.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Once a topic is chosen for guideline development, a work group is formed to draft the guideline. By design, the work group consists of psychiatrists in active clinical practice with diverse expertise and practice experience relevant to the topic.

Policies established by the Steering Committee guide the work of systematically reviewing data in the literature and forging consensus on the implications of those data, as well as describing a clinical consensus. These policies, in turn, stem from criteria formulated by the American Medical Association to promote the development of guidelines that have a strong evidence base and that make optimal use of clinical consensus.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Each recommendation is identified at falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the recommendation:

[I] Recommended with substantial clinical confidence
[II] Recommended with moderate clinical confidence
[III] May be recommended on the basis of individual circumstances

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Each practice guideline is extensively reviewed at multiple draft stages. Draft 1 is reviewed by the Steering Committee. Draft 2 is reviewed by approximately 50 reviewers with expertise in the topic, representatives of allied organizations, the American Psychiatric Association (APA) Assembly, District Branches, the Joint Reference Committee, the Board of Trustees, the Council on Quality Care, other components related to the subject area, and any APA member by request. Draft 3 is reviewed and approved for publication by the Assembly and the Board of Trustees.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. Definitions of the categories of endorsement are provided at the end of the "Major Recommendations" field.

1. Initial Assessment

The initial step in identifying individuals with acute stress disorder (ASD) or post traumatic stress disorder (PTSD) involves screening for recent or remote trauma exposure, although the clinical approach may vary depending on the recency of the traumatic event [I]. If eliciting vivid and detailed recollections of the traumatic event immediately after exposure enhances the patient's distress, the interview may be limited to gathering information that is essential to provide needed medical care [I]. The first interventions in the aftermath of an acute trauma consist of stabilizing and supportive medical care and supportive psychiatric care and assessment [I]. After large-scale catastrophes, initial psychiatric assessment includes differential diagnosis of physical and psychological effects of the traumatic event (e.g., anxiety resulting from hemodynamic compromise, hyperventilation, somatic expressions of psychological distress, fatigue) and identification of persons or groups who are at greatest risk for subsequent psychiatric disorders, including ASD or PTSD [I]. This identification may be accomplished through individual evaluation, group interviews, consultation, and use of surveillance instruments [I].

Diagnostic evaluation may be continued after the initial period has passed and a physically and psychologically safe environment has been established, the individual's medical condition has been stabilized, psychological reassurance has been provided, and, in disaster settings, necessary triage has been accomplished. It is important for this diagnostic assessment to include a complete psychiatric evaluation that specifically assesses for the symptoms of ASD and PTSD, including dissociative, reexperiencing, avoidance/numbing, and hyperarousal symptom clusters and their temporal sequence relative to the trauma (i.e., before versus after 1 month from the traumatic event) [I]. Other important components of the assessment process include functional assessment, determining the availability of basic care resources (e.g., safe housing, social support network, companion care, food, clothing), and identifying previous traumatic experiences and comorbid physical or psychiatric disorders, including depression and substance use disorders [I].

2. Psychiatric Management

Psychiatric management for all patients with ASD or PTSD includes instituting interventions and activities to ensure physical and psychological safety, required medical care, and availability of needed resources for self-care and recovery [I]. The patient's level of functioning and safety, including his or her risk for suicide and potential to harm others, is always important to evaluate during initial assessment and may determine the treatment setting [I]. The goals of psychiatric management for patients with ASD and PTSD also include establishing a therapeutic alliance with the patient; providing ongoing assessment of safety and psychiatric status, including possible comorbid disorders and response to treatment; and increasing the patients understanding of and active adaptive coping with psychosocial effects of exposure to the traumatic event, such as injury, job loss, or loss of loved ones [I]. Additional goals of psychiatric management include providing education regarding ASD and PTSD, enhancing treatment adherence, evaluating and managing physical health and functional impairments, and coordinating care to include collaborating with other clinicians [I].

3. General Principles of Treatment Selection

The goals of treatment for individuals with a diagnosis of ASD or PTSD include reducing the severity of ASD or PTSD symptoms, preventing or treating trauma-related comorbid conditions that may be present or emerge, improving adaptive functioning and restoring a psychological sense of safety and trust, limiting the generalization of the danger experienced as a result of the traumatic situation(s), and protecting against relapse [I].

Patients assessed within hours or days after an acute trauma may present with overwhelming physiological and emotional symptoms (e.g., insomnia, agitation, emotional pain, dissociation). Limited clinical trial evidence is available in this area, as randomized designs are difficult to implement; however, clinical experience suggests that these acutely traumatized individuals may benefit from supportive psychotherapeutic and psychoeducational interventions [II]. Pharmacotherapy may be the first-line intervention for acutely traumatized patients whose degree of distress precludes new verbal learning or nonpharmacological treatment strategies [II]. Research has not consistently identified patient- or trauma-specific factors that predict the development of ASD or interventions that will alter the evolution of ASD into PTSD. However, early after a trauma, once the patient's safety and medical stabilization have been addressed, supportive psychotherapy, psychoeducation, and assistance in obtaining resources such as food and shelter and locating family and friends are useful [II].

Effective treatments for the symptoms of ASD or PTSD encompass psychopharmacology, psychotherapy, and psychoeducation and other supportive measures [I]. Although studies using a combination of these approaches for ASD and PTSD are not presently available, combination treatment is widely used and may offer advantages for some patients [II]. The psychotropic medications used in clinical practice and research for the treatment of ASD and PTSD were not specifically developed for these disorders but have been used in doses similar to those recommended or approved for other psychiatric illnesses.

For patients with ASD or PTSD, choice of treatment includes consideration of age and gender, presence of comorbid medical and psychiatric illnesses, and propensity for aggression or self-injurious behavior [I]. Other factors that may influence treatment choice include the recency of the precipitating traumatic event; the severity and pattern of symptoms; the presence of particularly distressing target symptoms or symptom clusters; the development of interpersonal or family issues or occupational or work-related problems; preexisting developmental or psychological vulnerabilities, including prior trauma exposure; and the patient's preferences [I].

When the patient's symptoms do not respond to a plan of treatment, selection of subsequent interventions will depend on clinical judgment, as there are limited data to guide the clinician. It is important to systematically review factors that may contribute to treatment nonresponse, including the specifics of the initial treatment plan and its goals and rationale, the patient's perceptions of the effects of treatment, the patient's understanding of and adherence to the treatment plan, and the patient's reasons for nonadherence

if nonadherence is a factor [I]. Other factors that may need to be addressed in patients who are not responding to treatment include problems in the therapeutic alliance; the presence of psychosocial or environmental difficulties; the effect of earlier life experiences such as childhood abuse or previous trauma exposures; and comorbid psychiatric disorders, including substance-related disorders and personality disorders [I].

4. Specific Treatment Strategies

- Psychopharmacology

  Although it has been hypothesized that pharmacological treatment soon after trauma exposure may prevent the development of ASD and PTSD, existing evidence is limited and preliminary. Thus, no specific pharmacological interventions can be recommended as efficacious in preventing the development of ASD or PTSD in at-risk individuals.

  For patients with ASD, there are few studies of pharmacological interventions. However, selective serotonin reuptake inhibitors (SSRIs) [II] and other antidepressants [III] represent reasonable clinical interventions that are supported by limited findings in ASD as well as by findings of therapeutic benefits in patients with PTSD.

  SSRIs are recommended as first-line medication treatment for PTSD [I]. In both male and female patients, treatment with SSRIs has been associated with relief of core PTSD symptoms in all three symptom clusters (reexperiencing, avoidance/numbing, hyperarousal). Other antidepressants, including tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs), may also be beneficial in the treatment of PTSD [II].

  Benzodiazepines may be useful in reducing anxiety and improving sleep [III]. Although their efficacy in treating the core symptoms of PTSD has not been established, benzodiazepines are often used in trauma-exposed individuals and patients with PTSD. However, clinical observations include the possibility of dependence, increased incidence of PTSD after early treatment with these medications, or worsening of PTSD symptoms after withdrawal of these medications. Thus, benzodiazepines cannot be recommended as monotherapy in PTSD.

  In addition to being indicated in patients with comorbid psychotic disorders, second generation antipsychotic medications (e.g., olanzapine, quetiapine, risperidone) may be helpful in individual patients with PTSD [III]. Anticonvulsant medications (e.g., divalproex, carbamazepine, topiramate, lamotrigine), alpha-2-adrenergic agonists, and beta-adrenergic blockers may also be helpful in treating specific symptom clusters in individual patients [III].

- Psychotherapeutic Interventions

  Some evidence is available about the effectiveness of psychotherapeutic intervention immediately after trauma in preventing development of ASD or PTSD. Studies of cognitive behavior therapy in

motor vehicle and industrial accident survivors as well as in victims of rape and interpersonal violence suggest that cognitive behavior therapies may speed recovery and prevent PTSD when therapy is given over a few sessions beginning 2-3 weeks after trauma exposure [II].

Early supportive interventions, psychoeducation, and case management appear to be helpful in acutely traumatized individuals, because these approaches promote engagement in ongoing care and may facilitate entry into evidence-based psychotherapeutic and psychopharmacological treatments [II]. Encouraging acutely traumatized persons to first rely on their inherent strengths, their existing support networks, and their own judgment may also reduce the need for further intervention [II]. In populations of patients who have experienced multiple recurrent traumas, there is little evidence to suggest that early supportive care delivered as a stand-alone treatment will result in lasting reductions in PTSD symptoms. However, no evidence suggests that early supportive care is harmful. In contrast, psychological debriefings or single-session techniques are not recommended, as they may increase symptoms in some settings and appear to be ineffective in treating individuals with ASD and in preventing PTSD.

No controlled studies of psychodynamic psychotherapy, eye movement desensitization and reprocessing (EMDR), or hypnosis have been conducted that would establish data-based evidence of their efficacy as an early or preventive intervention for ASD or PTSD.

For patients with a diagnosis of ASD or PTSD, available evidence and clinical experience suggest that a number of psychotherapeutic interventions may be useful. Patients with ASD may be helped by cognitive behavior therapy and other exposure-based therapies [II]. In addition, cognitive behavior therapy is an effective treatment for core symptoms of acute and chronic PTSD [I]. EMDR also appears to be effective [II]; however, therapeutic benefit for the rapid eye movement component of this therapy has not been consistently demonstrated. Stress inoculation, imagery rehearsal, and prolonged exposure techniques may also be indicated for treatment of PTSD and PTSD-associated symptoms such as anxiety and avoidance [II]. The shared element of controlled exposure of some kind may be the critical intervention.

Psychodynamic psychotherapy may be useful in addressing developmental, interpersonal, or intrapersonal issues that relate to the nature, severity, symptoms, or treatment of ASD and PTSD and that may be of particular importance to social, occupational, and interpersonal functioning [II].

Case management, psychoeducation, and other supportive interventions may be useful in facilitating entry into ongoing treatment, appear not to exacerbate PTSD symptoms, and in some pilot investigations have been associated with PTSD symptom

reduction [II]. Present-centered and trauma-focused group therapies may also reduce PTSD symptom severity [III].

Definitions

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the efficacy of the treatment for the disorder and conditions described.

[I] Recommended with substantial clinical confidence
[II] Recommended with moderate clinical confidence
[III] May be recommended on the basis of individual circumstances

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through extensive review of multiple drafts of each guideline. In addition, each reference at the end of the original guideline document is followed by a letter code in brackets that indicates the nature of the supporting evidence, as follows:

[A] Randomized, double-blind clinical trial. A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; and both the subjects and the investigators are "blind" to the assignments.

[A] Randomized clinical trial. Same as above but not double blind.

[B] Clinical trial. A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally. Does not meet standards for a randomized clinical trial.

[C] Cohort or longitudinal study. A study in which subjects are prospectively followed over time without any specific intervention.

[D] Case-control study. A study in which a group of patients is identified in the present and information about them is pursued retrospectively or backward in time.

[E] Review with secondary data analysis. A structured analytic review of existing data, (e.g., a meta-analysis or a decision analysis).

[F] Review. A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.

[G] Other. Opinion-like essays, case reports, and other reports not categorized above.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Improved assessment and treatment outcomes of adult patients with acute stress disorder and post traumatic stress disorder

POTENTIAL HARMS

- Successful treatment may require patients to tolerate intense affect and/or disruptive or unpleasant medication side effects.
- Use of benzodiazepines may produce an increased incidence of post traumatic stress disorder (PTSD) after early treatment or worsening of PTSD symptoms after benzodiazepine withdrawal. There are also concerns about addictive potential in individuals with comorbid substance use disorders, which may prompt additional caution regarding use of benzodiazepines.
- In-depth exploration of the traumatic event and the patient's experiences may increase patient distress and result in increased symptom severity.
- Insensitive or premature exploration of recent life threatening events or losses may cause the patient to avoid medical care.
- Discussion of distressing memories and events in heterogeneously exposed groups may adversely affect those with little or no exposure when they hear of the frightening and terrifying experiences of others.
- Psychological debriefing may increase symptoms in some patients.
- Nefazodone has been associated with irreversible and life-threatening hepatic failure.

CONTRAINDICATIONS

CONTRAINDICATIONS

- While psychosocial treatments that attempt to identify and process traumatic experiences may be effective for individuals from Western cultures, they may be contraindicated for some Southeast Asian populations and persons from other non-Western cultures.
- Clinicians reluctance to prescribe monoamine oxidase inhibitors (MAOIs) generally relates to concerns about the capacity of patients to adhere to tyramine-free diets or to abstain from alcohol, certain drugs of abuse, and contraindicated prescription medications (e.g., selective serotonin reuptake inhibitors [SSRIs], central nervous system [CNS] stimulants, decongestants, and meperidine).

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

This guideline is not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual patient and are subject to change as scientific knowledge and technology advance and patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome for every patient, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Psychiatric Association. Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Arlington (VA): American Psychiatric Association; 2004 Nov. 57 p. [463 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Nov

GUIDELINE DEVELOPER(S)

American Psychiatric Association - Medical Specialty Society

SOURCE(S) OF FUNDING

American Psychiatric Association (APA)

GUIDELINE COMMITTEE

Work Group on ASD and PTSD

Steering Committee on Practice Guidelines

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Work Group Members: Robert J. Ursano, MD (Chair); Carl Bell, MD; Spencer Eth, MD; Matthew Friedman, MD, PhD; Ann Norwood, MD; Betty Pfefferbaum, MD, JD; Robert S. Pynoos, MD; Douglas F. Zatzick, MD; David M. Benedek, MD (Consultant)

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research

or other academic endeavors. It is possible that through such activities some contributors have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. The guideline has been extensively reviewed by members of the American Psychiatric Association (APA) as well as by representatives from related fields. Contributors and reviewers have all been asked to base their recommendations on an objective evaluation of available evidence. Any contributor or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work has been asked to notify the APA Department of Quality Improvement and Psychiatric Services. This potential bias is then discussed with the work group chair and the chair of the Steering Committee on Practice Guidelines. Further action depends on the assessment of the potential bias.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the American Psychiatric Association's Web site.

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1400 K Street NW, Washington, DC 20005; (202) 682-6262; (800) 368-5777; fax (202) 789-2648.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Treating patients with acute stress disorder and posttraumatic stress disorder. A Quick Reference Guide. Washington, DC: APA, 2004. Electronic copies: Available in Portable Document Format (PDF) from the American Psychiatric Association (APA) Web site.
- American Psychiatric Association practice guideline development process. Washington, DC: APA, 2004.Electronic copies: Available in Portable Document Format (PDF) from the APA Web site.

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1400 K Street NW, Washington, DC 20005; (202) 682-6262; (800) 368-5777; fax (202) 789-2648.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on December 1, 2004. The information was verified by the guideline developer on January 4, 2005. This

summary was updated by ECRI on February 23, 2005, following the release of a public health advisory from the U.S. Food and Drug Administration regarding the use of Gabitril. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI on October 3, 2005, following the U.S. Food and Drug Administration advisory on Paxil (paroxetine). This summary was updated by ECRI on December 12, 2005, following the U.S. Food and Drug Administration advisory on Paroxetine HCL - Paxil and generic paroxetine. This summary was updated by ECRI on May 31, 2006 following the U.S. Food and Drug Administration advisory on Paxil (paroxetine hydrochloride).

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Date Modified: 10/9/2006